December 14, 2020

Dear President-Elect Biden,

The Association for Behavioral Health and Wellness (ABHW) congratulates you on your election and looks forward to working with you and your Administration. We also want to thank you for recognizing during the campaign the growing need for mental health (MH) and substance use disorders (SUD) care and treatment.

ABHW serves as the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat MH, SUDs, and other behaviors that impact health and wellness.

Through our policy work, ABHW aims to increase access, drive integration, support prevention, eliminate stigma, and promote evidence-based treatment. Overarchingly, we promote equal access to quality treatment for all and therefore have focused our policy work to bring attention to systemic racism, which results in stark inequities in behavioral health care. We are deeply concerned about health disparities in this country in the area of MH and SUD services, and like you, are interested in continuing to address systemic racism not only in the healthcare system but in all avenues of American life. We look forward to working with you on these goals as we work to improve behavioral health services in this country.

Behavioral health services will be a continuing need as a result of social isolation, job loss, illness and death, and domestic violence related to COVID-19; these critical needs will continue long after the protective measures are lifted. The following legislative and policy issues can play a critical role in expanding access to MH and SUD services to provide long lasting improvements to our nation's behavioral health system. We outline the issues below for your consideration:

- Issue regulation for 42 CFR Part 2

Association for Behavioral Health and Wellness
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- Support COVID – 19 relief legislation
- Expand the use of telehealth for MH and SUD services
- Increase access to medication assisted treatment (MAT)
- Support suicide prevention efforts
- Eliminate the Institutions for Mental Diseases (IMD) Medicaid exclusion
- Develop a clear, universal compliance standard related to mental health and addiction parity
- Strengthen and expand the behavioral health workforce
- Ensure health coverage for individuals released from jails and prisons

In your first 100 days, we urge you to:

Issue regulation for 42 CFR Part 2. We strongly urge you to meet the March 27, 2021, deadline and issue the 42 CFR Part 2 (Part 2) rule pursuant to the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which passed in March 2020. Under the CARES Act, requirements from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be applied to Part 2. The 1970s federal regulations that govern the confidentiality of drug and alcohol treatment and prevention records sets requirements limiting the use and disclosure of patients' SUD records from certain substance use programs. The CARES Act permits a patient to provide one written consent to disclose their Part 2 information for all future treatment, payment, or health care operations (TPO), unless the patient revokes consent. If the Part 2 Program is breached, the patient is required to be notified. It also enforces the same civil and criminal penalties that are under HIPAA and prohibits discrimination against Part 2 Program patients in areas such as housing, employment, and government benefits. This legislation culminates years of work from a broad range of organizations, and it represents a number of critical compromises.

Attached you will find recommendations from the Partnership to Amend 42 CFR Part 2 (Partnership). ABHW founded the Partnership to bring various factions of the health care industry together to advocate for aligning Part 2 with HIPAA. The recommendations will be submitted to the Department of Health and Human Services (HHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) for consideration as they begin drafting the next Part 2 Rule due to be released in March, 2021.

Support COVID – 19 relief legislation and emergency supplemental funding for behavioral health services. We urge your Administration to work with Congress to pass emergency relief legislation to address the ongoing MH and SUD needs during the pandemic. Maintaining existing provider infrastructure, expanding access to care, and addressing workforce shortages in order to ensure people who need MH and SUD treatment get the care they need continues to be vitally important. Supplemental funding that assists, states, localities, and behavioral health providers is critically needed as we see increased overdoses and deaths due to overdoses, and a growing need to address mental health crises and suicide prevention.

Expand the use of telehealth for MH and SUD services. We appreciate the guidance and flexibilities offered during the current public health emergency (PHE) and request that your Administration continue the flexibilities, through December 31, 2021, or for an extended period of time following the lifting of the PHE. These needed changes have allowed payers and providers to ensure people can access necessary MH and SUD services in midst of physical distancing. ABHW member companies support extending flexibilities during the PHE while collecting and analyzing data to make informed decisions about making permanent changes. As the need for behavioral health services continues to grow, we urge Congress and your Administration to consider the following:

- *Eliminate geographic and originating site requirements*. We support permanently removing the geographic restrictions on originating sites, and the addition of the home as an originating site. This has been a long- standing policy for ABHW and will allow for individuals in rural areas or with limited access to services to receive the care they need in a timely manner. The response to COVID-19 has shown the importance of making telehealth services available in rural and urban areas alike. In order to bring clarity and provide certainty to patients, providers, and payers, we strongly urge you to work with Congress to address these restrictions in statute by striking section 1834(m) of the Social Security Act. This provision, which provides geographic limitation on originating sites, should be eliminated to allow beneficiaries across the country to receive virtual care in their homes, or location of their choosing, where clinically appropriate and with beneficiary protections and guardrails in place.

- *Expand cross state licensure*. During the pandemic, all 50 states have used emergency authority to waive some aspect(s) of state licensure laws providing widespread access to care. We encourage efforts for states to foster cross state licensure reciprocity to support increased access to services. We also propose convening a task force of federal and state leaders to examine this issue and outline recommendations on changes that would increase access to services.

- *Examine audio–only telehealth services*. ABHW supports patient access to audio-only behavioral health services for the duration of the PHE. However, before audio-only services are made permanent, ABHW would encourage the appropriate regulatory agencies to conduct research as to whether or not behavioral health services provided via audio-only are an effective long-term strategy to provide quality, evidence-based, and clinically appropriate care. Currently, it is unclear whether audio-only is appropriate for all behavioral health treatments. Specifically, ABHW advocates for audio-only services to be evaluated in partial hospitalization programs, applied behavioral analyses, psych testing, and group therapy before they are reimbursed permanently. Regulatory agencies should evaluate how to best modify requirements for telephonic modifier codes, quality standards, and protections against potential fraud, waste, and abuse. Ultimately, audio-only behavioral health treatments should have safeguards built around them and should not be a primary or default avenue for care. Post PHE, audio-only should only be used after it has proven to be effective and is deemed to be in the individual's best interest (for example, the patient has limited broadband access and difficulty accessing video technology).

Increase access to medication assisted treatment (MAT). During the COVID-19 pandemic, overdoses have grown and drug involved deaths continue to rise. Expanded access to MAT is needed now more than ever. In your first 100 days in office, we ask that your Administration work with Congress to pass the Mainstreaming Addiction Treatment (MAT) Act, H.R. 2482 and S. 2074. This bipartisan legislation would remove the federal rules established by the DATA 2000 Act that require health care practitioners to obtain a waiver from the Drug Enforcement Administration (DEA) before prescribing buprenorphine to treat

opioid use disorders (OUDs). The legislation would remove a major hurdle to prescribing, thereby increasing the number of providers able to provide MAT.

Additionally, we encourage your Administration to permanently eliminate the in-person evaluation requirement from the Ryan Haight Act. While there is a temporary removal during the PHE of the requirements from the Ryan Haight Act that providers conduct an in-person evaluation prior to prescribing medicine via telehealth services, we support permanently eliminating this requirement. There is little evidence to support this policy and it creates a barrier to medically necessary care. Given that not all individuals with SUDs are able to have an initial in-person visit with a provider due to behavioral health provider shortages or physical difficulty traveling, ABHW advocates for actions which would eliminate the in-person evaluation requirement before a provider can utilize MAT. This includes urging the Drug Enforcement Administration (DEA) to move forward with the telemedicine special registration process required by federal law that will enable providers to prescribe MAT to patients with SUDs by employing telemedicine. The Special Registration for Telemedicine Act (which is a part of the SUPPORT Act) calls for the Attorney General, in consultation with the HHS Secretary, to promulgate final regulations specifying the limited circumstances in which a special registration may be issued and the procedure for obtaining a special registration. In drafting this much anticipated regulation, we advocate for MAT to be included in the "limited circumstances" so patients with SUDs have access to the care they need.

Support suicide prevention efforts. This year, Congress passed the National Suicide Hotline Designation Act of 2019, now making the National Suicide Prevention Lifeline a three-digit number, 9-8-8. It is more evident than ever that Americans must be able to readily access mental health crisis services through a ubiquitous, easy-to-remember phone number like 9-8-8. We urge HHS to work with the Federal Communications Commission (FCC) to ensure a timely implementation of 9-8-8 by July 2022. Incidences of mental health crises and suicides have been increasing annually, and will be exasperated by the social, health, and economic impact of the COVID-19 pandemic.

In addition to swiftly putting the crisis line into place, it is equally important that the crisis line have adequate resources so that it can operate effectively and handle call and crisis chat volume to ensure all Americans have access. Since demand will undoubtedly increase for services of the crisis line, there will need to

be significant investment after the initial implementation to expand capacity and provide services consistently for mental health crises. Therefore, we ask that you work with Congress to pass H.R. 4564, the Suicide Prevention Lifeline Improvement Act. This legislation would require increased coordination, data sharing, and provide more funding to support community-based crisis service delivery.

The following are additional policy priorities we look forward to addressing over the next year.

Eliminate the Institutions for Mental Diseases (IMD) Medicaid exclusion. We urge Congress to remove policy barriers that limit beneficiary access to needed and appropriate MH and SUD care. This includes ending the IMD exclusion, which prohibits Medicaid reimbursement for adults under the age of 65 in residential behavioral health facilities with more than 16 beds. Although the IMD exclusion cannot be fully overcome without Congressional action, the Administration could increase access and improve appropriate care through expanded use of waivers under section 1115 to enable states to more broadly cover IMD services. Further, as we have witnessed, national hospital capacity has been pushed to its limits during the COVID-19 pandemic. Waiving the IMD exclusion to Medicaid funding for inpatient behavioral health treatment would free up beds in local hospitals allowing them to better manage the surge capacity in both inpatient and emergency departments to care for COVID-19 patients.

Develop a clear, universal compliance standard related to mental health and addiction parity. For more than two decades, ABHW has supported mental health and addiction parity. We were an original member of the Coalition for Fairness in Mental Illness Coverage (Fairness Coalition), a coalition developed to win equitable coverage of mental health treatment. ABHW served as the Chair of the Fairness Coalition in the four years prior to passage of Mental Health Parity and Addiction Equality Act (MHPAEA) in 2010. We were closely involved in the writing of the Senate legislation that became MHPAEA, and actively participated in the negotiations of the final bill that became law. ABHW member companies have worked vigorously to understand and implement MHPAEA. We have had numerous meetings with the regulators to help us better understand the regulatory guidance and to discuss how plans can operationalize the regulations. Our member companies have teams of dozens of people working diligently to implement and provide a MH/SUD parity benefit to their consumers.

Parity has progressed since its adoption in a meaningful way and access to MH and SUD treatment providers has greatly expanded – though systemic issues continue to be a challenge due to other non-parity factors such as the looming shortage of physicians, including psychiatrists, and other providers. Examples of key changes since the parity law and regulations were enacted include: the fact that routine MH outpatient treatment no longer habitually requires prior authorization or has explicit quantitative treatment limits; evidence-based levels of care for MH conditions are no longer subject to blanket exclusions (e.g., residential treatment for eating disorders); and transparency, documentation, attention to medical necessity criteria all have improved.

However, despite these gains and the parity language in the 21st Century Cures Act, aspects of the law and regulations remain overly complex and technical. As a result, compliance has become a moving target through a patchwork of conflicting and changing guidance. We support the flexibility built into the law, yet we have seen the proliferation of different compliance approaches, tools, and interpretations, which has led to confusion and is costly for stakeholders. We believe your Administration can re-invigorate efforts to clarify and improve the application of the law for the benefit of all.

We look forward to bringing the payer's perspective to the conversation on strengthening the behavioral health system and ensuring patients realize the benefits of MHPAEA. As stated previously, ABHW supports MHPAEA and we would like to work with the Administration and the appropriate federal agencies on a universal compliance standard that is not unnecessarily burdensome.

Strengthen and expand the behavioral health workforce. We encourage Congress to seek solutions to expand access to care, and address ongoing workforce shortages across the country in order to help ensure people who need MH and/or SUD treatment get the care they need. As one first step, we ask that the Administration and Congress work to increase funding to behavioral health providers so that we have an adequate workforce to meet the increasing need for MH and SUD services. We recommend expanding eligible Medicare providers to include marriage and family therapists, mental health counselors, and certified peer support specialists.

- *Medicare coverage of mental health counselors and marriage and family therapists.* ABHW recommends recognizing mental health counselors (MHCs) and marriage and family therapists (MFTs) as covered Medicare providers to address the gaps in care for Medicare beneficiaries. Recognition of MHCs and MFTs would increase the pool of eligible mental health professionals by over 200,000 licensed practitioners. Studies have shown that these providers have the highest success and lowest recidivism rates with their patients as well as being the most cost effective.[1] We encourage you to work with Congress to pass the Mental Health Access Improvement Act (H.R. 945/ S. 286), which recognizes MHCs and MFTs as covered Medicare providers, helps address the critical gaps in care, and ensures access to needed services.

- *Medicare coverage of peer support services.* Certified peer support specialists can be vital in providing support to people living with mental health conditions and SUDs. These paraprofessionals are individuals with lived experience of recovery from a MH disorder or SUDs. This evidence-based practice helps individuals navigate the often-confusing health care system, get the most out of treatment, identify community resources, and develop resiliency. Assisting with these activities is even more critical during the current pandemic as individuals and communities are social-distancing and sheltering in place. Engaging with treatment and care has been disrupted; and finding and utilizing support in a timely manner can help mitigate negative health outcomes. This year the Promoting Effective and Empowering Recovery Services in Medicare (PEERS) Act of 2020, H.R. 8206, was introduced. This legislation is an important step in recognizing the unique role of peer support specialists in helping individuals better engage in services, manage physical and mental health conditions, build support systems, and, ultimately, live self-directed lives in their communities.

Ensure health coverage for individuals released from jails and prisons. ABHW strongly supports H.R. 1329, the Medicaid Reentry Act, to grant Medicaid eligibility to incarcerated individuals 30-days prior to their release to promote the

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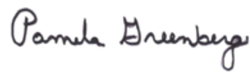
[1] D. Russell Crane and Scott H. Payne, "Individual Versus Family Psychotherapy in Managed Care: Comparing the Costs of Treatment by the Mental Health Professions," Journal of Marital & Family Therapy 37, no. 3 (2011): 273-289.

health care needs of individuals transitioning back into communities. According to the Bureau of Justice Statistics, more than half of those in the criminal justice system suffer from a mental illness. Of those with serious mental illness, approximately 75 percent also have a co-occurring SUD. Allowing incarcerated individuals to receive services covered by Medicaid 30-days prior to their release from jail or prison will expand access to vital mental health and addiction services. Equipping individuals with timely access to addiction, mental health, and other health-related services before release, will facilitate the transition to community-based care upon release that is necessary to help break the cycle of recidivism. This is even more critical in the midst of the coronavirus pandemic.

Thank you for the opportunity to provide suggestions to address important behavioral health policies. If you have any questions or would like to discuss ABHW's policy priorities please contact me at greenberg@abhw.org or 202-449-7660.

Sincerely,



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